CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

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TITLE: Minnesota Prepaid Medical Assistance Project Plus (PMAP+)

AWARDEE: Minnesota Department of Human Services

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I. PREFACE

The following are Special Terms and Conditions for the extension of Phase 2 of the Minnesota Prepaid Medical Assistance Project Plus (PMAP+). The Special Terms and Conditions have been arranged into three broad subject areas: General Conditions for Approval, Legislation, and Program Design/Operational Plan.

In addition, specific requirements are attached entitled: General Financial Requirements (Attachment A); General Administrative Requirements (Attachment B); General Reporting Requirements (Attachment C); Monitoring Budget Neutrality for PMAP+ (Attachment D); Access Standards (Attachment E); Operational Protocol (Attachment F); Recommended Encounter Data Set Elements (Attachment G) and County-Based Purchasing (Attachment H).

The State agrees that it will comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to: the American with Disabilities Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. As part of the review of the operational protocol that the State is required to submit, CMS will examine the State's proposed operational procedures to ensure their consistency with the requirements set forth in the above Federal statutes.

Letters, documents, reports, or other material that is submitted for review or approval shall be sent to the Minnesota Demonstration Project Officer and the Minnesota State Representative from the Chicago Regional Office.

II. GENERAL CONDITIONS

A. Prior to program implementation of Phase 2, the protocol document required by Special Term and Condition II.B, below, must be approved by the Health Care Financing Administration.

B. The State shall prepare one protocol document that represents and provides a single source for the policy and operating procedures applicable to Phase 1 and Phase 2 of this demonstration which have been agreed to by the State and HCFA during the course of the waiver negotiation and approval process. The protocol must be submitted to HCFA no later than 60 days prior to the implementation of Phase 2. HCFA will respond within 45 days of receipt of the protocol regarding any issues or areas it believes require clarification. During the demonstration, changes to the protocol which are the result of major changes in policy or operating procedures should be submitted to HCFA for approval no later than 90 days prior to the date of implementation of the change(s). The Special Terms and Conditions and Attachments include requirements which should be included in the protocol. Attachment F is an outline of areas that should be included in the protocol.

C. The State will comply with:

1. General Financial Requirements (Attachment A)
2. General Administrative Requirements (Attachment B)
3. General Reporting Requirements (Attachment C)
4. Monitoring Budget Neutrality for PMAP+ (Attachment D)
5. Access Standard (Attachment E)
6. Operational Protocol (Attachment F)
7. Recommended Encounter Data Set Elements (Attachment G)
8. County-Based Purchasing (Attachment H)

III. LEGISLATION

A. All requirements of the Medicaid program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are part, shall apply to PMAP+. To the extent the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS shall incorporate such effects into a modified budget limit for PMAP+. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. CMS will have two years after the waiver award date to notify the State that it intends to take action. The growth rates for the budget neutrality baseline, as described in Attachment D, are not subject to this Special Term and Condition. If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by PMAP+ (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit shall be proportional to the size of PMAP+ in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

B. The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the waiver award date. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of the waiver, CMS shall incorporate such changes into a modified budget limit for PMAP+. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program components that are or are not affected by PMAP+ (e.g., laws affecting sources of Medicaid funding), the State shall submit its methodology to CMS for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in Minnesota, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments shall be made according to the method applied in non-Section 1115 waiver States.

C. The State may submit to CMS a request for an amendment to PMAP+ to request exemption from changes in law occurring after the waiver award date. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under a modified PMAP+ demonstration do not exceed projected expenditures in the absence of the PMAP+ demonstration (assuming full compliance with the change in law).

IV. PROGRAM DESIGN/OPERATIONAL PLAN

A. Managed Care Marketing, Education, and Enrollment

The Special Terms and Conditions in this section apply to beneficiaries eligible to enroll in the Prepaid Medical Assistance Program or Prepaid MinnesotaCare. All communication with beneficiaries must be consistent with the Americans with Disabilities Act's prohibition on unnecessary inquiries into the existence of a disability.

1. Marketing-

a. Marketing is defined as any communication from a Managed Care Organization (MCO), any of its agents or independent contractors, with an enrollee or a potential enrollee that can reasonably be interpreted as intended to influence that individual to enroll or reenroll in that particular MCO's Medicaid product. All marketing activities related to managed care will be conducted in accordance with Section 1932(d)(2) and CMS's marketing guidelines.

b. Marketing materials means materials that:

1. Are produced in any medium, by or on behalf of an MCO; and

2. Can reasonably be interpreted as intended to influence individuals to enroll or reenroll in that particular MCO's Medicaid product.

c. All written materials (including marketing, enrollment and member handbooks) will be written in prose that is easily understandable in format, with a reading level no higher than seventh grade. The State shall make every effort to have information available in alternative formats and in a manner that takes into consideration the special needs of those who, for example, are visually impaired or have limited reading proficiency. MCO's must provide instructions to potential enrollees on how to obtain information in the appropriate format. Marketing brochures and presentation materials, including handbooks, used by marketing representatives should follow QARI standard X.D. - Enrollee Rights and Responsibilities, Communication of Policies to Enrollees/Members.

d. Bilingual material (including marketing, enrollment, and member handbooks) should be available, and provided to single-language minority households if approximately five percent or more (using the most recent year of Census Bureau data available) of those low-income households in a geographic region are of a single-language minority. (Single-language minority households refers to households which speak the same non-English language and which do not contain adult(s) fluent in English as a

second language.) If a client speaks a language that does not meet the threshold, the carrier must still assure that the client receives information in his/her primary language by providing interpreters, etc.

In addition, all material sent to Medicaid beneficiaries by the State, will include a language block, printed in the seven languages required by State law, that informs the beneficiary that the document contains important information, and directs the beneficiary to call the State or county to have the document translated. All materials sent to Medicaid beneficiaries by the MCO will include a language block printed in the seven languages required by State law, that informs the beneficiary that the document contains important information, and directs the beneficiary to call the MCO to have the document translated.

e. The State will approve all marketing materials prior to their use by the MCO or any of its subcontractors, agents, independent contractors, employees and providers. The materials shall be provided to CMS upon request. CMS reserves the right to require modification to marketing materials if deemed necessary.

f. Direct marketing is marketing done by the MCO or its employees, while indirect marketing is marketing done by the MCO's agents, independent contractors acting or anyone else, acting on behalf of the MCO. All MCOs will have equal opportunity to participate in marketing activities. However, MCOs or any of their subcontractors, agents, independent contractors, employees and providers are prohibited from telephone marketing, cold-calling, face-to-face marketing, promotion, and conducting door-to-door marketing activities.

g. Providers will be able to post signs in their offices stating that they are members of an MCO, provided that equal representation of each MCO to which he or she belongs is also posted. Health education materials for enrollees may be made available in provider's offices, including those which contain the logo of the MCO.

h. Minnesota's regulations and its contracts with MCOs will have provisions that permit enforcement of these prohibitions.

2. Beneficiary Education/Enrollment -

a. All beneficiary education about enrollment activities and all enrollment activities will be done by the State, the local agency, or a tribe. An MCO will be prohibited from conducting this activity.

b. The State, the local agency, or the tribe shall send each eligible beneficiary an enrollment packet. The enrollment packet, at a minimum, shall contain the following information:

i. A comprehensive listing of MCOs and affiliated providers including primary care providers, hospitals, NF facilities and identification of providers that are not accepting new patients within the beneficiary's service area;

ii. Information concerning the selection process including a statement that the beneficiary must choose an MCO in which their primary care provider or specialist participates if they wish to continue to obtain services from him/her;

iii. Information indicating that the beneficiary will be assigned an MCO to enroll in if an MCO selection is not made;

iv. Information regarding an individual's right to change MCOs and the frequency at which a change can be made, as well as the right to change MCO assignment at any time, without limitation, for cause;

v. Benefits including amount, duration, and scope of benefits available under the contract;

vi. Procedures for obtaining benefits, including authorization requirements. This includes the policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider;

vii. Information that clearly explains the substance abuse and mental health (behavioral health) services available, as well as how the behavioral health system may be accessed;

viii. Any restrictions on the enrollee's freedom of choice among network providers;

ix. The extent to which after-hours and emergency coverage is provided;

x. Cost sharing;

xi. Information describing the complaint, grievance and appeals process;

xii. Information regarding Medicaid covered services to which enrollees may be entitled but are not covered under the MCO contract;

xiii. Information regarding free choice of family planning services; the availability of transitional services; and

xiv. A statement that informs beneficiaries about additional information and special assistance that is available and how it can be obtained.

c. The following information must be furnished to eligible beneficiaries upon request:

i. With respect to MCOs and health care facilities, their licensure, certification, and accreditation status;

ii. With respect to health care professionals, information that includes, but is not limited to, education, licensure, and Board certification and recertification;

iii. Other information on requirements for accessing services to which they are entitled under the contract, including factors such as physical accessibility.

iv. A listing of all providers within an MCO s network, including specialty and sub-specialty providers and pharmacies.

d. The following information must be provided to each eligible beneficiary annually and upon their request. This information will be furnished within a time frame that enables them to use the information in choosing among available MCOs:

i. The MCO s available in the beneficiary s service area;

ii. The benefits covered under the contract;

iii. Any cost sharing;

e. As part of the protocol, the State must submit to CMS the default assignment algorithm that is utilized in assigning eligible beneficiaries who do not select an MCO in which to enroll. Should the approved default assignment algorithm change during the duration of the demonstration, the proposed algorithm must be submitted to CMS for approval prior to its use. The effective date of enrollment into an MCO for a beneficiary who is assigned to an MCO after the assignment must be specified. Prior to the effective date of enrollment, the State shall provide enrollees with the name and telephone number of the MCO to which they have been assigned and notify them of their right to change MCOs within the first year without cause and to change providers within the MCO every 30 days. Within fifteen (15) days of the receipt of enrollment data, the MCO shall provide

enrollees with member information. The MCO shall take appropriate action to ensure that new enrollees who need special or immediate health care services, as identified by their provider, will receive them in a timely manner. The State will monitor the default assignment rate. If it is determined that the default assignment rate is consistently higher than 40 percent, a corrective action plan will be initiated.

f. Beneficiaries will be entitled to change their MCO assignment annually during the open enrollment period. Beneficiaries will be entitled to change their MCO assignment at any time, without limitation, for cause.

g. Once enrollment activities have been initiated in an expansion county(ies), CMS reserves the right to halt enrollment at any time if there are serious and uncorrected problems in the beneficiary enrollment/disenrollment process; if the management information systems necessary to administer the program are insufficient; if there are problems with beneficiary access or quality; or if there is a serious problem that jeopardizes the quality or delivery of care to beneficiaries. CMS will promptly notify the State if a potential or existing problem has been identified and will permit the State to implement a corrective action plan prior to halting enrollment. If the corrective action plan is unsuccessful and CMS is forced to stop the program in the specific county(ies), the State and CMS will work expeditiously to resolve the problem(s). Once the problem(s) is resolved, implementation may proceed.

h. Throughout the demonstration, the State or local agency will maintain a sufficient number of staff to accommodate concerns and questions of beneficiaries regarding enrollment into an MCO.

B. Eligibility

As part of the protocol, the State will describe the following:

1. Eligibility Expansion Groups - The eligibility process for each eligibility group defined in Attachment A.

2. Eligibility Modifications - Detailed information about modifications in the eligibility process for traditional Medical Assistance eligibility groups, including:

a. Elimination of six-month income reviews for medically needy beneficiaries with only unvarying unearned income or excluded income;

b. Elimination of quarterly income review requirement and income requirements for the second six months for transitional MA beneficiaries;

c. Exclusion of gift income under $ 100 per month from countable income for all MA eligibility groups;

d. Elimination of post-partum review for certain pregnant women;

e. Determination of MA eligibility for children under age two and pregnant women using an income standard of 275 percent of the Federal Poverty Guidelines (FPG) with no asset standard;

f. Extension by one month of MA eligibility for managed care enrollees determined ineligible for not submitting a completed household report form or an eligibility redetermination form;

g. Extension of automatic eligibility through the month in which they become age two for infants who were automatically MA eligible from birth to age one, without a re-evaluation of eligibility.

C. Benefits and Coordination of Services

1. PMAP: Nursing Facility (NF) - MCOs will be required to cover 90 days of NF care for PMAP enrollees who were not residing in a NF at the time of PMAP enrollment, or for enrollees who were residing in the NF at the time of PMAP enrollment, left the NF for more than 180 days, and later returned to the NF. As part of the protocol, the State shall submit a plan detailing the process, coordination, and time lines among MCOs, contracted and non-contracted facilities, the county pre-admission screening (PAS) teams and hospital discharge planners for individuals who are hospital discharges, emergency placements, or enrollees living in the community but seeking to enter nursing homes. In addition, the State shall include minimum quality assurance standards and a description of how the MCO's ability to meet these standards will be monitored throughout the demonstration. The State must describe in its protocol, and have in place throughout the demonstration, a mechanism for enrollees to receive the appropriate care if it is determined that the MCO is unable to meet their needs.

2. PMAP and Prepaid MinnesotaCare: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) - All MCOs will be responsible for arranging for the provision of, or providing, the full range of EPSDT services in accordance with the contract with the State, to recipients under age 21 years. The State is responsible for ensuring that MCOs are aware of this requirement and fully understand what EPSDT services encompass. The State must monitor MCOs to ensure that this is occurring through the use of, at a minimum, encounter data, HEDIS reports or medical record reviews.

3. PMAP, Prepaid MinnesotaCare, and Dental Projects - The State must demonstrate that an adequate dental network is in place to ensure that enrollees can receive medically necessary dental care. The plan for monitoring the adequacy of this network throughout the demonstration shall be included in the protocol.

4. PMAP and Prepaid MinnesotaCare: Behavioral Health -

a. The State must demonstrate that an adequate network is in place to provide substance abuse treatment and mental health services. A plan for monitoring the adequacy of the network throughout the demonstration will be included in the protocol.

b. Coordination of Care for Enrollees in Need of Mental Health and Substance Abuse Treatment Services - The State shall encourage MCOs to actively identify enrollees in need of mental health and substance abuse services. As part of the annual report required under Attachment C, the State shall provide a description of the approaches taken by MCOs to achieve this.

c. Coordination of Care - As part of the protocol, the State must describe how MCOs are expected to coordinate care for enrollees with such entities as: public health agencies, school-based health clinics, and family planning clinics. The description shall include the process for exchanging patient specific information while protecting the confidentiality of the patient.

5. PMAP and Prepaid MinnesotaCare: Prescription Drugs -

a. The State shall require that MCOs provide medically necessary prescription drugs and over-the-counter drugs that are included in the drug formulary under the State's Medicaid plan or that are the therapeutic equivalent.

b. The State shall have in place (and describe in the protocol) a mechanism to monitor the adequacy of an MCO's drug formulary throughout the demonstration. The State will intervene on behalf of the enrollee if the enrollee or his or her provider notifies the State of a problem accessing medically necessary drug treatments, due to less comprehensive MCO drug formularies or underlying restrictive policies. The State shall require that the MCO arrange for providing the necessary drug(s), and that the cost of providing such drug(s) not be borne by the enrollee. Further, such a problem shall initiate an MCO corrective action plan by the State.

6. Cost Sharing -

a. The demonstration does not involve the implementation of copayments, premiums, or deductibles of any kind for Medical Assistance beneficiaries.

b. MinnesotaCare enrollees are responsible for premiums based on income and household size. Children under 150 percent of the federal poverty level (FPL) pay a $ 4 per month premium. Pregnant women and children under age two are not disenrolled for nonpayment of premiums. Parents and caretaker adults will be responsible for copayments including $ 3 for prescription drugs; $ 25 for eyeglasses; and 50 percent of restorative dental

services (excluding orthodontia) for enrollees whose income does not exceed 175 percent of the FPL.

D. Managed Care Delivery Network

1. PMAP and Prepaid MinnesotaCare MCO Contracting -

a. Contracts - Prior CMS approval is required for model contracts with MCOs and any significant deviation from the model contract. CMS will make a determination to approve or disapprove model contracts within 45 days of receipt. All final MCO contracts are subject to written approval through the appropriate CMS Regional Office. The State will submit a final model contract to CMS, along with any plan-specific changes from the model and the final signature pages of each contract. The actual delivery of services and the availability of Federal Financial Participation (FFP) for services under the contract may not occur until the final contract is signed by the MCO and the State, but may be effective immediately upon signing, as long as substantial changes have not been made in the terms approved in the model contract. Contracts shall contain a clear description of the services that the State expects the MCO to provide and a description of the activities the State expects the MCO to perform, as well as descriptions of the requirements they must meet.

b. Subcontracts - Copies of subcontracts or individual provider agreements with MCOs shall be provided to CMS upon request. The State will approve all MCO model subcontracts related to medical services, assignment of risk, data reporting functions and any substantial deviations from these model subcontracts.

c. Prior to being designated as an MCO for participation in PMAP+ and being permitted to enroll any eligible beneficiaries, each organization that is interested in participating in the demonstration (regardless of the fact that they may be an HMO licensed in the State) must undergo a rigorous qualifications review by the State, or an agent of the State. The standards for meeting this qualification review must be submitted to CMS for approval as part of the protocol and shall include, at a minimum, qualification measures in the following areas: MCO capacity and patient access, quality assurance systems, data systems, reporting capabilities, and solvency standards. CMS reserves the right to request the results of a specific organization's qualifications review and to require re-evaluation if deemed necessary. MCOs must be made aware of these qualification standards as part of the qualification process.

2. Beneficiary Choice - In areas of the State where there is only one MCO participating, the State must submit a plan for CMS approval that details how a beneficiary will have choice for health care services without incurring additional costs. Counties that are not currently participating in PMAP+ will be required to

have this plan in place prior to initiating enrollment in that area.

3. Health Services to American Indian Populations Enrolled in PMAP - Prior to implementation, the State will detail in its protocol the PMAP+ out-of-network purchasing model for American Indian recipients of Medical Assistance. American Indian beneficiaries would be required to participate in PMAP, whether residing on or off a reservation, but could access out-of-network services at IHS or 93-638 facilities. The State must ensure that MCOs are aware of this right. Beneficiary marketing and enrollment material must clearly explain this right. A monitoring instrument and protocol to assess health delivery services within PMAP+ and out-of-network and how information will be exchanged regarding service delivery will be included in the State's protocol. Information from this monitoring will be included in the State's quarterly reports as well as documentation of continuing discussions and consultations with the tribes that includes details of problems and concerns regarding service delivery and access to care.

4. Prepaid Dental Care Project -

   a. The State has CMS approval to pursue a demonstration whereby a Medical Assistance or MinnesotaCare beneficiary may be required to obtain Medical Assistance or MinnesotaCare coverage of dental services from a regulated entity or local provider network that is under contract with the State. Under such a demonstration, coverage of dental services would be carved out of the applicable comprehensive PMAP or Prepaid MinnesotaCare contract.

   b. The State will use the Request for Proposal (RFP) process to select contracting regulated entities or local provider networks. Ninety days prior to the issuance of an RFP, the State will submit for CMS approval, a detailed description of the demonstration that includes payment rates and the methodology used in their determination; how the contracts will require MCOs and dental plans to coordinate care for the beneficiaries; how the system will be accessed; network capacity; how quality, delivery of care and beneficiaries' access to care will be monitored; complaint and grievance procedures; and how provider beneficiary education will be conducted. This information will be incorporated in the State's protocol.

   c. Within 90 days of award, the State will submit an implementation work plan for approval by the CMS project officer that will specify time frames for major milestones and related subtasks. Upon approval, this document will be incorporated in the protocol.

5. Children's Integrated Mental Health Project -

   a. The State has CMS approval to pursue a demonstration project permitting the formation of local collaboratives to develop integrated mental health and social services for children who have or who are at risk of severe

emotional disturbance. The local collaborative may choose to provide mental health services to MA-eligible children within a prepaid, risk-based arrangement.

b. The State will use the RFP to select contracting local collaboratives. Ninety days prior to the issuance of an RFP, the State will submit for CMS review and approval a detailed description of the demonstration that addresses CMS's June 4, 1999 draft interim review criteria for Children with Special Health Care Needs and any subsequent guidance that may be issued prior to this submission by the State; includes all capitation rates for the Children's Mental Health Collaborative Managed Care Project and the methodology used in their determination; a detailed discussion of the Health Plan's contract with the local collaborative to deliver the Medical Assistance mental health services for children in the identified target population; the coordination of referrals and access to care; the maintenance of patient confidentiality; the utilization of services by enrollees; and the quality assurance monitoring plan. This information will be incorporated in the State's protocol.

c. Within 90 days of award, the State will submit an implementation work plan for approval by the CMS project officer that will specify time frames for major milestones and related subtasks. Upon approval, this document will be incorporated in the protocol.

6. Provider Payment -

a. Capitation Rates - The State will submit to CMS for review and approval all capitation rates for any MCOs or plans during the demonstration. Included will be the methodology for determining special rate adjustments.

b. PMAP Medical Education - Also to be reflected in the overall methodology will be the removal of Medical Assistance Payments for the cost of medical education. As part of the protocol the State will describe the methodology for determining the amount of monies to remove from the PMAP capitation rate to a medical education trust fund and the methodology for distributing these funds to teaching entities. A list of eligible institutions and the percentage of these funds they will receive should be included.

7. Solvency Requirements - Upon request, the State shall provide to CMS copies of all financial statements and audits performed by certified public accountants and filed with the Minnesota Department of Commerce or the Department of Health by MCOs. If a State audit of an MCO reveals evidence that an entity is experiencing solvency difficulties, the audit results and related documentation shall be sent to CMS within 30 days of completion of the audit. Further, the State shall provide to CMS, upon request, copies of all audits conducted by the State under the Federal Single Audit Act. If an MCO becomes insolvent, no FFP will

be available for direct payment by the State to any provider for services provided to the MCO's enrollees if those services were provided in the time period covered by the capitation payment paid to the MCO for that enrollee.

8. Disclosure Requirements - The State will meet the usual Medicaid disclosure requirements at 42 CFR 455, Subpart B.

E. Access to Services

1. PMAP and Prepaid MinnesotaCare Access Standards -

a. The State must demonstrate to CMS that, prior to enrollment in an expansion county and on an ongoing basis thereafter, as well as in counties that are currently participating in PMAP and Prepaid MinnesotaCare, beneficiaries will have access to an adequate number of nursing homes and hospitals, service sites (including dental), and allied professional services. The State must provide the methodology it is using as part of the MCO evaluation and selection process to determine whether each MCO has sufficient capacity. The methodology for conducting this analysis shall be submitted as part of the protocol and should, at a minimum, take into consideration the incidence of providers affiliated with multiple MCOs, the commercial caseload of providers, and the geographic distribution of beneficiaries in relationship to providers. If CMS decides to run a computer mapping program, the State shall provide addresses of demonstration eligibles and providers in an electronic format. (Specific access standards are listed in Attachment E.)

b. As part of its protocol, the State must provide CMS with an annually updated list of all participating MCOs and their providers (primary and specialty).

c. The State will notify CMS immediately of any significant changes to any provider network that affect access, and the State shall define within its protocol contingency plans for assuring continued access to care for enrollees in the case of contract termination or insolvency.

d. The State must monitor MCOs to ensure that they are conforming with the standards outlined in the Americans with Disabilities Act for purposes of communicating with, and providing accessible services to hearing and vision impaired, and physically disabled beneficiaries.

F. Quality Assurance

1. Monitoring Plan for MCOs and Prepaid Health Plans (PHPs) -

a. As part of the protocol, the State shall describe an overall quality assessment and improvement strategy for MCOs and PHPs. (Note that the

Prepaid Dental Health Project and the Children's Integrated Mental Health Project are considered PHPs). The quality assessment and improvement strategy must:

i. Specify MCO and PHP structural and operational standards (i.e., CMS's QISMC standards) to which all MCOs and PHPs will be held accountable;

ii. Describe the methods and frequency (no less frequently than every three years) with which MCOs and PHPs will be monitored for compliance with the structural and operational standards;

iii. At least annually, measure access and quality using valid and reliable performance measures (as specified in the protocol) that measure processes of clinical care and services (and when feasible, measure outcomes of care);

iv. Compare access and quality measurement results to benchmarks established and described by the State; and

v. Include a quality improvement process for all MCOs and PHPs.

b. The State must further:

i. Submit to CMS the results monitoring review findings for compliance with structural and operational standards as part of the annual report;

ii. Submit to CMS all results of performance measurements submitted to the State by the MCO or PHP as part of the annual report.

2. The Children's Integrated Mental Health Project - Within 90 days prior to implementation, the State shall submit a quality assessment and improvement plan for the Children's Integrated Mental Health Project. The plan must include: measures to assure that beneficiaries have sufficient access to appropriate care and relevant quality measures.

3. Prepaid Dental Health Project - Within 90 days prior to implementation, the State must provide its overall quality assessment and improvement plan for the Prepaid Dental Care Project. This must include a discussion of all performance measures it plans to routinely collect and study and the methodology for measuring such measures.

4. External Quality Review Organization (EQRO) - The State will meet all applicable Federal requirements for annual external independent quality review of MCOs and PHPs, as articulated in Federal statute at 1932(c)(2). The State shall submit a summary of the EQRO report to CMS as part of their annual report.

5. Guidelines for MCO Monitoring of Providers - MCOs will require, by contract, that affiliated providers meet specified standards as required by the State regulations and contract. MCOs will monitor, on a periodic or continuous basis, (but no less often than every 12 months) providers' adherence to these standards.

6. Enrollee Survey - The State shall conduct an annual enrollee survey, such as the Consumer Assessment of Health Plan Study (CAHPS--Medicaid version). The survey shall be generally described in the operational protocol and provided to CMS upon request. At a minimum, the survey will include such measures as enrollee's satisfaction with access and the quality of care of services delivered by the MCO or PHP. Such surveys shall be designed to produce statistically valid results. Survey results will be provided to CMS in the State's annual report.

7. Grievance and Appeal Process - The State shall monitor the complaint/grievance process to assure that enrollees' concerns are resolved timely; that confidentiality is protected; and that coordination between the MCO, Ombudsman, and State is occurring in an efficient and effective manner. At a minimum, as part of this monitoring effort, the State shall collect and review quarterly reports on grievances received by each MCO, including a description of the resolution of each formal grievance. Quarterly reports must also include an analysis of logs of informal complaints (which may be verbally reported to customer service personnel) as well as descriptions of how formal (written) grievances and appeals were handled.

G. Encounter Data Requirements

1. Minimum Data Set - As part of its protocol, the State shall include its minimum data set (which at least includes all inpatient hospital and physician services) and require (as part of the State's regulations and contract) that all MCOs and PHPs submit these data. (The recommended minimum encounter data set elements are identified in Attachment G.) The State must perform periodic reviews, including periodic (at least annually) validation studies of encounter data accuracy and completeness, in order to ensure compliance and shall have contractual provisions in place to impose financial penalties if accurate data is not submitted in a timely fashion. The description will include a work plan showing how collection of this encounter data will be validated, as well as how the State will use the encounter data to monitor implementation of the project in new and existing counties, set rates, and incorporate findings into the development of program enhancement on a timely basis. If the State fails to provide to CMS or its evaluator reasonably accurate and complete encounter data for any MCO, the State will be responsible for providing to the designated CMS evaluator data abstracted from medical records comparable to the data that would be available from encounter reporting.

2 Quality Improvement - The State will include in its protocol a description of how the encounter data is being used to pursue health care quality improvement; where

the data is stored; how data is validated; how monitoring occurs; and what penalties will be incurred if information is not provided. At a minimum, the State's plan for using encounter data to pursue health care quality improvement must describe how the data will be used to study significant utilization and access issues in priority areas, such as:

- childhood immunizations;
- prenatal care;
- pediatric asthma;
- dentistry;
- and other areas to be determined by the State as significant based upon the population(s) served.

ATTACHMENT A
GENERAL FINANCIAL REQUIREMENTS

1. The State shall provide quarterly expenditure reports using the Form HCFA-64 to separately report expenditures for services provided under the Medicaid program and those provided through PMAP+ under section 1115 authority. CMS will provide Federal Financial Participation (FFP) only for allowable PMAP+ expenditures that do not exceed the pre-defined limits as specified in Attachment D.

2. a. In order to track expenditures under this demonstration, the State will report PMAP+ expenditures through MBES, following routine HCFA-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. In this regard, expenditures subject to the budget neutrality cap will be differentiated from other Medicaid expenditures by identifying them on separate Forms HCFA-64.9 and/or 64.9p, with the demonstration project number assigned by CMS (including the project number extension, which indicate the demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual.

   b. For each demonstration year, four separate Forms HCFA-64.9 and/or 64.9p should be submitted reporting expenditures subject to the budget neutrality cap. Please provide separate reports for MinnesotaCare Children under age 21, MA Children Age One, Pregnant Women and Adult Caretakers. The sum of these sheets should represent the expenditures subject to the budget neutrality cap reported in that quarter.

   c. Administrative costs will not be included in budget neutrality, but the State must separately track and report additional administrative costs that are attributable to the demonstration.

   d. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. During the period following the conclusion or termination of the demonstration, the State must continue to separately identify expenditures subject to the budget neutrality cap, using the procedures addressed above.

3. a. For the purpose of calculating the budget neutrality limit, the State shall provide to CMS on a quarterly basis the actual number of eligible member/months for each of the four eligibility groups (EGs) defined in 3.c. This information should be provided to CMS 30 days after the end of each quarter as part of the quarterly progress report. To permit full recognition of "in-process" eligibility, reported counts of member months shall be subject to minor revisions for an additional 180

days after the end of each quarter. For example, the counts for the quarter ending September 30, 1999, due to be reported by October 30, 1999 are permitted to be revised until June 30, 2000.

b. The term, "eligible member/months" shall refer to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member/months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member/months.

c. The term "PMAP+ Demonstration eligibles" includes: the **MinnesotaCare Children EG** who are children enrolled in MinnesotaCare under age 21. The **Medical Assistance (MA) Children EG** who are children age one enrolled in Medicaid with family incomes between 133 percent and 275 percent of the Federal Poverty Level (FPL), including children who are part of the automatic extended newborn eligibility group. The **Pregnant Woman EG** who are pregnant women up to sixty days post-partum who are enrolled in MinnesotaCare. The **Adult Caretakers EG** who are adults enrolled in MinnesotaCare, who have Medicaid eligible children enrolled in this demonstration or under the Medicaid State Plan.

4. The standard Medicaid funding process will be used during the demonstration. Minnesota must estimate matchable Medicaid expenditures on the quarterly Form HCFA-37. The State must provide supplemental schedules that clearly distinguish between at-risk estimates subject to the cap (by major component) and Medicaid estimates that are not at-risk. CMS will make Federal funds available each quarter based upon the State's estimates, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form HCFA-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form HCFA-64 with Federal funding previously made available to the State for that quarter, and include the reconciling adjustment in a separate grant award to the State.

5. CMS will provide Federal Financial Participation (FFP) at the applicable Federal matching rate for the following, subject to the limits described in Attachment D:

a. Administrative costs, including those associated with the administration of PMAP+;

b. Net expenditures of the Medicaid program and prior period adjustments which are paid in accordance with the approved State Plan as modified by approved waivers under 1915(b), 1915(c), and 1115 of the Social Security Act;

c. PMAP capitation expenditures;

d. Beginning July 1, 1995, CMS will provide FFP on a statewide basis for expenditures related to coverage of pregnant women and children under age 21

enrolled in MinnesotaCare with family incomes up to 275 percent of the FPL; as well as children age one in Medical Assistance with family incomes between 133 percent and 275 percent of FPL. FFP will be provided for the cost of coverage minus premiums, copayments and other individual contributions paid by MinnesotaCare eligibles. Beginning on February 22, 1999, CMS will provide FFP for expenditures (net of premiums, copayments and other individual contributions) related to coverage for caretaker adults enrolled in MinnesotaCare with family incomes up to 275 percent of FPL. The total amount of FFP for all four types of eligibles over the three-year period of the extension (July 1, 2002 through June 30, 2005) shall not exceed the limit described in Attachment D.

Minnesota shall not receive FFP for expenditures on behalf of any person who is not either (1) a pregnant woman, child under age 21 or, after February 22, 1999, a caretaker adult enrolled in MinnesotaCare; (2) a child age one enrolled in Medicaid who is not part of the extended automatic newborn eligibility group and with family income between 133 percent and 275 percent of FPL; (3) a child age one enrolled in Medicaid who is part of the extended automatic newborn eligibility group; (4) for one month, a managed care enrollee determined ineligible for not submitting a completed household report form or an eligibility report form; (5) a person eligible under Minnesota's current Medicaid State plan; (6) eligible under 5(e) of this Attachment. Minnesota shall receive FFP for expenditures for persons who are eligible under Minnesota's current Medicaid State plan without the FFP limit described in Attachment D.

For pregnant women enrolled in MinnesotaCare, Minnesota shall receive FFP for expenditures for services included in the full Medicaid benefit package identified under Minnesota's current Medicaid State plan for a qualified pregnant woman.

d. Effective upon implementation, Minnesota shall receive FFP for expenditures for the Prepaid Dental Project and the Children's Integrated Mental Health Project.

e. Effective upon implementation, CMS will provide FFP for expenditures related to coverage of Medical Assistance recipients whose eligibility is determined:

   i. For a 12-month period without application of a 6-month budget period for medically needy recipients who are receiving only unvarying unearned income or whose sole source of income is excluded from consideration.

   ii. For a 12-month period without application of the quarterly income review requirement or the 185 percent of the FPL income limit for transitional Medical Assistance recipients.

   iii. Without counting gifts of money less than or equal to $ 100 per month.

   iv. To continue, for pregnant women after the end of the post-partum period, until coverage would be provided under some other category at the time of households next regularly scheduled eligibility review date, provided the

woman was eligible for Medical Assistance prior to pregnancy or lives with other household members eligible for Medical Assistance on the same basis of eligibility and income standard as the woman.

7. The State will certify State/local monies used as matching funds for PMAP+ and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

8. Effective January 1, 1999, States are required to submit Medicaid eligibility and claims information to CMS through the Medical Statistical Information System (MSIS). Section 2700 of the State Medicaid Manual when submitting eligibility and claims information for it's expanded eligibility group.

ATTACHMENT B

GENERAL PROGRAM REQUIREMENTS

1. To be included as part of the State's contract with an MCO, the State shall require MCOs to protect the confidentiality of all project-related information that identifies individuals. The provisions must specify that such information is confidential and, that it may not be disclosed directly or indirectly except for purposes directly connected with the conduct of the project or the administration of the Medicaid program, including evaluations conducted by the independent evaluator selected by the State and/or CMS, or evaluations performed or arranged by State agencies. Informed written consent of the individual must be obtained for any other disclosure.

2. The State's MCO contracts and subcontracts for services related to PMAP+ must provide that the State agency and the U.S. Department of Health and Human Services may: (1) evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed and (2) inspect and audit any financial records, including those concerning reimbursement rates, of such contractor/subcontractors.

3. CMS will contract with an independent contractor to evaluate the demonstration. The State agrees to cooperate with the evaluator (at no cost to the evaluator), by responding in a timely manner to requests for interviews, providing access to records, and sharing data, including the claims, encounter, and eligibility files. The State has the right to review reports and the right to comment on reports prepared by the evaluator prior to public distribution.

4. CMS may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. CMS reserves the right to withhold waivers pending or to withdraw waivers at any time if it determines that granting or continuing the waivers would no longer be in the public interest. If the waiver is withdrawn, CMS will be liable for only normal close-out costs.

5. The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for the suspension or termination, together with the effective date. If the waiver is withdrawn, CMS will be liable for only normal close-out costs.

ATTACHMENT C

GENERAL REPORTING REQUIREMENTS

1. By April 1 of each year, the State will submit Form HCFA-416, EPSDT program reports for the previous Federal fiscal year. These reports will follow the format specified in section 2700.4 of the State Medicaid Manual, with data for each line item arrayed by age group and basis of eligibility. All data reported will be supported by documentation consistent with the general requirements of these terms and conditions.

2. CMS and the State will hold monthly calls to discuss progress. Further, the State will submit quarterly progress reports which are due 60 days after the end of each quarter. The reports should include, as appropriate, a discussion of events occurring during the quarter that affect health care delivery, including access and coordination of in-plan and out-of-plan services; NF referrals and utilization; enrollment and outreach activities; default assignments; quality of care; complaints and grievances; other operational and policy issues including those related to American Indians enrolled in PMAP, Prepaid Dental Care Project and Children's Integrated Mental Health Project; and budget neutrality or fiscal issues. The report should include a separate discussion of State efforts related to the collection and verification of encounter data. The report should also include proposals for addressing any problems identified in each report.

3. The State will submit a draft annual report documenting accomplishments; project status; findings from any research studies conducted during the year; a summary of annual EQRO reviews of MCOs and PHPs; copies of quality monitoring reviews of structural and operational standards of MCOs and PHPs; results of performance measurements submitted to the State by MCOs and PHPs; results of the enrollee survey; changes to benefit packages; and policy and administrative difficulties; and MCO approaches to identifying enrollees in need of mental health and substance abuse services. This report will be submitted no later than 120 days after the end of its operational year. Within 30 days of receipt of comments from CMS, a final annual report will be submitted.

4. At the end of the demonstration, a draft final report should be submitted to CMS for comments. CMS's comments must be taken into consideration by the State for incorporation into the final report. The State should use HCFA, Office of Research and Demonstrations' Author's Guidelines: Grants and Contracts Final Reports in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.

5. The State will submit a phase-out plan of the demonstration to CMS six months prior to initiating normal phase-out activities or, if desired by the State, an extension plan on a timely basis to prevent disenrollment of members if the waiver is extended by CMS. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than six months when such action is necessitated by emergency circumstances. The phase-out plan is subject to CMS review and approval.

ATTACHMENT D

MONITORING BUDGET NEUTRALITY FOR PMAP+

1. Minnesota will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the extension period. This limit will apply to expenditures made on behalf of persons enrolled in MinnesotaCare and children age one with family incomes between 133 percent and 275 percent of FPL who are made eligible for Federal financial participation (FFP) through the PMAP+ demonstration. The calculation of the limit is described in item 2 below.

2. a. For each State fiscal year (SFY) a separate annual limit is calculated. Each annual limit is the sum of up to four eligibility group (EG) estimates, corresponding to the four EGs defined in 3.c. of Attachment A.

   b. Each EG estimate will be calculated as the product of the number of eligible member/months reported by the State under item 3.c. of Attachment A for that EG, times the appropriate estimated per member/per month (PMPM) cost from the table in item 2d of this Attachment.

   c. The budget neutrality limit is the sum of the annual estimates for the demonstration period, less the amount of premiums, copayments and other individual contributions paid by MinnesotaCare eligibles. The Federal share of the budget neutrality limit represents the maximum amount of FFP that the State may receive for expenditures on behalf of eligibles described in item 3.c. of Attachment A during the demonstration period. For the purpose of this section, ninety days after the end of each quarter, the State shall report to CMS the total amount of premiums paid by MinnesotaCare eligibles in that quarter.

   d. The following are the estimated PMPM costs for the calculation of the budget neutrality limit for demonstration enrollees.

SFY	Children	MA Children	Pregnant Women	Adult Caretaker
2002	$121.97	$245.14	$957.78	$160.42
2003	130.95	263.18	1,034.40	173.25
2004	140.58	282.55	1,117.15	187.11
2005	150.93	303.35	1,206.53	202.08

ATTACHMENT E

ACCESS STANDARDS

Contractors shall provide available, accessible, comprehensive quality care to eligible beneficiaries through the use of an adequate number of hospitals and nursing facilities, service locations, service sites, and professional, allied, and paramedical personnel (including dental) for the provision of all covered services. These services must be available on an emergency basis, 24-hours-a-day, 7-days-a-week. The standards for making this care available shall include:

1. Primary Care

a. Distance/Time: No more than 30 miles or 30 minutes for all enrollees, subject to the State's generally accepted community standards*.

b. Adequate Resources: The State will require the MCO to have available, either directly or through arrangements, appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of its enrollees for covered health care services.

c. Timely Access: The MCO will arrange for covered health care services, including referrals to participating and nonparticipating providers, to be accessible to enrollees on a timely basis in accordance with medically appropriate guidelines consistent with generally accepted community standards*.

d. Appointment Times: Not to exceed 45 days from the date of a beneficiary's request for routine and preventive care and 48 hours for urgent care.

e. Tracking: All MCOs must have a system in place for confidential exchange of enrollee information with the primary care provider if a provider other than the primary care provider delivers health care services to the enrollee.

2. Specialty Care

a. Transport Time: Not to exceed one hour, subject to the State's generally accepted community standards.*

b. Appointment/Waiting Time: Appointments for a specialist (e.g., specialty physician services, hospice care, home health care, and rehabilitation services, etc.) shall be made in accordance to the time frame appropriate for the needs of the enrollee, and consistent with generally accepted community standards*.

3. Emergency Care/Shock Trauma

All emergency care must be provided on an immediate basis, at the nearest equipped facility available, regardless of contract affiliation.

4. Hospitals

Transport time not to exceed 30 minutes, subject to the State's generally accepted community standards.*

5. Dental, Optometry, Lab, and X-Ray Services

a. Transport Time: Not to exceed one hour, subject to the State's generally accepted community standards.*

b. Appointment/Waiting Time: Not to exceed 60 days for regular appointments and 48 hours for urgent care.

6. Pharmacy Services

Travel time not to exceed one hour, subject to the State's generally accepted community standards.*

7. Other

All other services not specified here shall meet the generally accepted community standards.*

8. Documentation

All entities providing care to beneficiaries (MCOs, PHPs, specialists, etc.) must have a general system in place to document adherence to the appropriate access standards (e.g. physicians - waiting times and appointment waiting times). The State must utilize statistically valid sampling methods for monitoring compliance with these standards (e.g. enrollee survey).

* "Generally accepted community standards" means access that is equal to or greater than that currently existing in the Medical Assistance fee-for-service system in a specific geographic area, i.e., urban or rural.

ATTACHMENT F

OPERATIONAL PROTOCOL

The State will be responsible for developing a detailed protocol describing the PMAP+ Demonstration. The protocol will serve as a stand alone document that reflects the operating policies and administrative guidelines of the demonstration. The protocol will be submitted for approval no later than 60 days prior to implementation of Phase 2. CMS will respond within 30 days of receipt of the protocol. The State shall assure and monitor compliance with the protocol. The protocol will include all requirements specified within the Special Terms and Conditions. The protocol will provide a description of each topic area with special attention to the following:

1. Administration:

   The organizational and structural administration that will be in place to implement, monitor, and run the demonstration, and the tasks that each will perform.

2. Beneficiary Marketing, Education and Enrollment:

   a. Marketing and outreach strategies and permissible marketing activities by the MCO.

   b. The enrollment and disenrollment process including the default assignment process (including how the determination is made of which MCO receives the assignment) and issuing of MCO membership identification cards.

   c. The complaint, grievance and appeal policies that will be in place at the State and MCO level, including a detailed description of the Ombudsman program.

3. Eligibility:

   a. The eligibility process for each eligibility group defined in Attachment A.

   b. Modifications in the eligibility process for traditional Medical Assistance Groups.

4. Benefits and Coordination of Services:

   a. The Medicaid services covered under the demonstration, including those subject to capitation and those otherwise reimbursed.

   b. The plan for monitoring the coordination of care, utilization, and payment for carve-out and out-of-plan services, including how the State will ensure that all necessary services are provided to clients without duplicate payments being made.

c. PMAP: Nursing Facility:

i. The process, coordination and time lines among MCOs, contracted and non-contracted facilities, the county pre-admission screening (PAS) teams and hospital discharge planners for individuals who are hospital discharges, emergency placements or enrollees living in the community but seeking to enter nursing homes.

ii. The mechanism for assuring that enrollees receive the appropriate care if it is determined that the MCO is unable to meet their needs.

d. PMAP, Prepaid Minnesota Care, Prepaid Dental Project and Children's Integrated Mental Health Project:

The plan for monitoring the adequacy of the provider network.

e. PMAP and Prepaid MinnesotaCare: Behavioral Health:

i. A plan for monitoring the adequacy of the provider network.

ii. The process for identifying someone who is need of services and how this would be monitored to ensure access to care.

iii. The coordination of care by MCOs for their enrollees with such entities as: public health agencies, school-based health clinics, and family planning clinics. Included will be the process for exchanging patient-specific information while protecting the confidentiality of the patient.

f. PMAP and Prepaid MinnesotaCare: Prescription Drugs:

The mechanism for monitoring the adequacy of an MCO's drug formulary.

g. MinnesotaCare: Cost sharing

5. Managed Care Delivery Network: PMAP and Prepaid MinnesotaCare:

a. The standards for meeting the qualification review for participation, which include, at a minimum, qualification measures in MCO capacity and patient access, quality assurance systems, data systems, reporting capabilities, and solvency standards.

b. Health Services to American Indian Populations Enrolled in PMAP- A monitoring protocol to assess health delivery services within PMAP and out-of-network and a description of how information about service delivery will be exchanged.

c. Prepaid Dental Care Project- A detailed description of this project as outlined in IV(D)(4) of this document.

d. Children's Integrated Mental Health Project- A detailed description of this project as outlined in IV(D)(5) of this document.

e. Provider Payment- All capitation rates, including the methodology for determining special rate adjustments. The methodology for determining the amount of monies to remove from the PMAP capitation rate to a medical education trust fund and the methodology for distributing these funds to teaching entities. A list of eligible institutions and estimated percentage of funds they will receive will be included.

f. MCO financial and solvency reporting and monitoring requirements including:
   i. the ongoing plan for monitoring MCOs;

   ii. the hold harmless provisions that will be imposed on MCOs;

   iii. any reinsurance options the State offers to MCOs; and

   iv. contingency plans for ensuring continued access to care for enrollees in the case of an MCO contract termination or insolvency.

g. An annually updated list of all participating MCOs and their providers (primary and specialty).

h. Participation provisions for the Essential Community Providers.

i. The elements and process of the MCO readiness review to be jointly conducted by CMS and the State prior to the beginning of client marketing and enrollment in expansion counties.

6. Quality Assurance

a. Monitoring Plan for MCOs and PHPs- Quality assessment and improvement strategy to be implemented for all MCOs and PHPs as described in IV(F)(1) of this document.

b. Prepaid Dental Health Project and Children's Integrated Mental Health Project- Overall quality assessment and improvement plans that will be submitted 90 days prior to implementation.

c. Enrollee Survey

7. Encounter Data Requirements

a. The minimum data set for MCOs and PHPs, which includes all inpatient hospital and physician services. A work plan showing how collection of this encounter data will be monitored and validated, as well as how the State will use this encounter data to monitor implementation of the project in new and existing

counties, set rates, and incorporate findings in the development of program enhancements on a timely basis.

b. How the encounter data is being used to pursue health care quality improvement, where the data is stored, how data is validated, how monitoring occurs, and what penalties will be incurred if information is not provided.

ATTACHMENT G

Encounter Data Set Elements

ELEMENTS	TYPE OF RECORD				
	PHYS & OTHER PROVS	HOSP	LTC	DRUGS	DENTAL
Enrollee/Enrollee ID	X	X	X	X	X
Enrollee/Enrollee Name	X	X	X	X	X
Enrollee/Enrollee DOB	X	X	X	X	X
Plan ID	X	X	X	X	X
Physician/Supplier/Provider ID	X	X	X	X	X
Attending/Ordering/Referring Performing Physician ID	X	X	X	X	X
Provider Location Code/Address	X	X	X	X	X
Place of Service Code	X	X	X	-	X
Specialty Code	X	-	X	-	-
Date(s) of Service	X	X	X	X	X
Units of Service/Quantity	X	X	X	X	X
Principal Diagnosis Code	X	X	-	-	-
Other Diagnosis Code(s)	X	X	-	-	-
Procedure Code	X	X	X	-	-
EPSDT Indicator	X	-	-	-	X
Patient Status Code	-	X	X	-	-
Revenue Code	-	X	X	-	-
National Drug Code	-	-	X	X	-
Dental Quadrant	-	-	-	-	X
Tooth Number	-	-	-	-	X

ATTACHMENT H

COUNTY-BASED PURCHASING

These terms and conditions apply to the South Country Health Alliance and any other county-based purchasing projects which may in the future be approved separately under this demonstration by CMS. In addition, all other STCs associated with the Phase II approval shall apply to county-based purchasing projects.

1. Sixty (60) days prior to implementation, the state shall submit an addendum to the Operational Protocol describing operations in the county-based purchasing area, including the education process, phase-in of enrollment, PCP assignment, PCP changes, and conditions under which enrollees can access services outside of the county based purchasing network. The addendum shall be reviewed and approved by CMS prior to implementation.

2. Within ninety (90) days of approval of the South Country Health Alliance amendment, the state shall submit, for review and approval, a phase-out plan to be used in the event that any or all counties in a particular county based purchasing area decide to revert back to state-based purchasing. The plan shall address educating beneficiaries; transitioning enrollees from the county-based purchasing network to another network or fee-for-service medical assistance, and payments to providers. The plan shall also propose time lines for each of the aforementioned elements as well as time lines for notification of CMS in the event of such anticipated reversions. Subsequent county-based purchasing proposals should indicate whether this phase-out plan would be used in each area. If another phase-out plan is to be used, such plan should be submitted with the amendment application.

3. Effective with all quarterly progress reports and annual reports submitted after approval of the SCHA amendment, future reports will include a section on county-based purchasing. CMS and the State will agree to content and format specifications for future reports within 60 days of approval. At a minimum, such reports will include a discussion of events occurring during the period covered that affect health care delivery, including access to and integration of public health services, community social services, and medical services in and across counties; public health goals; consumer and provider outcomes; complaints and grievances; external quality review; and other operational and policy issues related to county-based purchasing including budget neutrality or fiscal issues. The report should include proposals for addressing any problems identified in each report.

4. CMS reserves the right to review and approve geographic expansions of the SCHA county-based purchasing project, or other county-based purchasing projects that may be approved in the future under this demonstration, and to conduct separate on-site readiness reviews prior to implementation of any county-based purchasing project under this demonstration. Such readiness reviews will address the state's and counties' readiness to proceed with county-based purchasing under the demonstration. CMS will want to verify the system's ability to ensure that a sufficient number of providers are contracted to allow appropriate access by enrollees for health care services; that systems are capable of supporting the requirements of the demonstration; that medical record retrieval systems are operable and accessible to the county ASO for quality assessment review, quality improvement activity, and utilization

review; and that training has occurred between system entities that have responsibilities related to the demonstration. CMS will want to verify that case management systems are operable and capable of providing a link between the ASO and the member counties to provide case management activity, provider and client placement tracking, and reports.

5. Any programmatic movement of counties, or eligibles within a county, from one county-based purchasing project to another county-based purchasing project, under this demonstration, shall require prior review and approval by CMS.

6. If eligibles for a particular county-based purchasing project under this demonstration are transitioned from state-based purchasing to county-based purchasing on a phased in basis, rather than all on a discrete date, the State shall provide for each county the initial number of individuals to be transitioned immediately prior to implementation, and for each month thereafter until the transition is complete, the number of demonstration eligibles in each county still under state-based purchasing (FFS) and the number transitioned to county-based purchasing (managed care) by eligibility group.

7. The State will provide advance copies to CMS of any formal presentation, by the State, a county-based purchasing entity, or an administrative services organization under contract with a county-based purchasing entity, that is based on information obtained through the administration of the county-based purchasing projects under this demonstration. Formal presentations include reports, statistical or analytical materials, papers, articles, professional publications, and speeches.